TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MARK H HENRY MD

Respondent Name
SERVICE LLOYDS INSURANCE COMPANY

MFDR Tracking Number
M4-16-0507-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill is for an emergency surgery. We find that none of the charges on this claim have been paid at 100% of the statutory fee as required by law per Texas Administrative Code Title 28 Part 2 Chapter 134 Subchapter C Rule 134.202[sic]."

Amount in Dispute: $2,202.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "To date CorVel has no record of existence of a business record for an out-of-network request from Mark Howard Henry, MD for approval by the network for out-of-network health care prior to services being rendered by the requestor. CorVel contends that the requestor, Mark Howard Henry, MD was required to obtain approval from the network for out-of-network health care prior to services being rendered."

Response Submitted by: CorVel

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
March 27, 2015	25609 and 73110	$2,202.59	$2,178.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. Texas Insurance Code §1305 applicable to Health Care Certified Networks.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 196 – Non Network Provider

Issue(s)

1. Did the out-of-network healthcare provider meet the requirements of Chapter §1305.006?
2. Did the requestor bill in accordance with 28 Texas Administrative Code §134.203 (b)?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed for CPT Codes 25609 and 73110 rendered on March 27, 2015 to an injured employee enrolled in a certified healthcare network. The requestor seeks a decision from the Division's medical fee dispute resolution (MFDR) section as an out-of-network healthcare provider. The insurance carrier denied/reduced the disputed charges with denial reason code "196 – Non Network Provider."

   The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 Texas Administrative Code §133.307.

   Chapter §1305.006 outlines the insurance carrier's liability for out-of-network healthcare and states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

   (1) emergency care;
   (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
   (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

   Texas Insurance Code §1305.153 (c) provides "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   The Divisions medical fee dispute resolution section, may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider rendered emergency care. The Division finds that the requestor has therefore, met the exception outlined in Chapter 1305.006(1). As a result, the disputed services are under the jurisdiction of the Division of Workers' Compensation and therefore, eligible for medical fee dispute resolution. The disputed services are reviewed pursuant to the applicable rules and guidelines, pursuant to Texas Insurance Code §1305.153(c).

2. The requestor billed for CPT Codes 25609 and 73110 rendered on March 27, 2015. For the reasons stated above the Division finds that insurance carrier's denial reasons are not supported and the requestor is entitled to reimbursement for the disputed service.

   28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   Procedure code 25609, service date March 27, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 14.38 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 14.65322. The practice expense (PE) RVU of 12.93 multiplied by the PE GPCI of 1.006 is 13.00758. The malpractice RVU of 2.76 multiplied by the malpractice GPCI of 0.955 is 2.6358. The sum of 30.2966 is multiplied by the Division conversion factor of $70.54 for a MAR of $2,137.12. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $2,122.64.

   Procedure code 73110, service date March 27, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.17 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.17323. The practice expense (PE) RVU of 0.79 multiplied by the PE GPCI of 1.006 is 0.79474. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.955 is 0.02865. The sum of 0.99662 is multiplied by the Division conversion factor of $56.20 for a MAR of $56.01.

3. The Division finds that the requestor is entitled to reimbursement in the amount of $2,178.65. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,178.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,178.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		April 12, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.